Learning To Crawl: The Use of Voluntary Caps on Damages in Medical Malpractice Litigation

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Abstract

Medical malpractice insurance "crises" seem to recur with distressing frequency. Indeed, the escalating costs of malpractice insurance premiums have become the focal point for advocates of tort reform. While we know quite a bit about the medical malpractice system, we know very little about what might work to fix things. Many reforms have been tried; little has worked. The two most commonly attempted reforms – at least at present- are legislatively imposed caps on non-economic damages (i.e., pain and suffering) and the use of screening panels. Neither of these alternatives offers a satisfactory resolution to the problem.

This article proposes the use of voluntary caps, selected (if at all) by the plaintiff and the plaintiff's attorney. By the use of three separate litigation "tracks," incentives can be provided for plaintiffs to agree to caps on damages, while also providing separate inducements for the insurers who defend malpractice defendants and the physicians that they insure. The underlying benefit for allwould be substantially reduced costs of litigation. The end result would be improved access to the courts for injured plaintiffs and a more rational claims resolution system.

Legislation implementing the proposal would not be necessary; tailored discovery scheduling orders would suffice. In a politically charged climate, broad scale, equitable reform is not likely. Instead, we should begin a steady movement towards such reform, in stages. We need to learn to crawl, before we can walk.

Learning to Crawl: The Use of Voluntary Caps in Medical Malpractice Cases

I. Introduction

Again we find ourselves in a medical malpractice crisis.[1] Observers who follow such things generally agree that the crisis of the early 2000s is the third such crisis in recent memory. The first appeared in the mid 1970s; the second appeared in the mid 1980s.[2] The crisis is, by and large, about the level of malpractice insurance premiums physicians pay. Rates have increased substantially in the last several years over most of the country, and the rates have increased for all medical and surgical specialties. Several surgical specialties, including Ob-Gyn and orthopedic surgery, have experienced particularly dramatic rate increases.[3] Beyond the attention paid to rising insurance premiums is the fear that for at least some specialties in some states, malpractice insurance is, or will soon become, unavailable.[4] From a concern over rising insurance rates and diminishing availability of insurance, the next worry – one of access to health care- comes naturally. Will escalating premiums lead a substantial number of physicians – Ob-

[1] Some writers prefer to place "crisis" in quotes, suggesting that the problem is a bit overstated. Certainly there is no shortage of overblown rhetoric in the continuing debate over medical malpractice reform. It is the position of this article that the quotation marks are irrelevant. What matters is that the situation is widely *perceived* as a crisis, certainly by physicians and politicians, as well as many others. A perception this widespread simply can't be ignored.

[2] See, generally, David M. Studdert et al., *Medical Malpractice,* 350 N.ENG. J. MED. 283, 284-5 (2004)(hereinafter Studdert et al., 2004a); William M. Sage, *Understanding the First Malpractice Crisis of the 21st Century,* in GOSFIELD, ed., HEALTH LAW HANDBOOK 2003. See also American Medical Association, *Medical Liability Reform- NOW!* at 2 (2004)(available at www.ama-assn.org/go/mlrnow, site visited December 23, 2004) (hereinafter American Medical Association 2004); Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFFAIRS, January 21, 2004.

[3] Thorpe, *supra* n. 2, at 21. See also General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Premium Rate Increases*, at 9-13, 31, GAO-03-702 (2003) (hereinafter GAO, *Multiple Factors*), William P. Gunnar, *Is There An Acceptable Answer to Rising Medical Malpractice Premiums?* 13 ANNALS HEALTH L. 465, 470-1 (2004).

[4] See, e.g., John Wagner, *Malpractice Pinch Has Maryland Doctors Mulling Whether to Wait or Leave,* WASHINGTON POST, B1, November 30, 2004; Sheri Hall, *Malpractice Rates Drive Off Doctors,* DETROIT NEWS, A1, October 25, 2004; Tanya Albert, *Two Illinois Towns Take Tort Reform Into Their Own Hands,* AMEDNEWS.COM, August 9, 2004; Rachel Zimmerman and Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis'*, WALL STREET JOURNAL, A1, June 24, 2002; American Medical Association, *supra* n.2 at 4, 9-10.

Gyns are almost always used in this sort of argument- to abandon the practice of medicine?[5] More precisely, will escalating premiums, or the difficulty in obtaining insurance, induce a substantial number of physicians practicing in, say, Pennsylvania or New York or North Carolina[6] to move to states with lower malpractice premiums? Although it may have been an answer, twenty-five or thirty years ago, for physicians to simply pass along the increased cost of insurance premiums by increasing the fees they charge, that option is much less realistic today. In a health care system dominated by managed care, it has become increasingly difficult for physicians to simply pass along their higher costs.[7] Nor is it an answer to say to a physician, much as one might to a 23 year old driver, that you must simply be more careful, and eventually your rates will come down. Unlike drivers, physicians within a particular specialty are usually not "experience-rated." [8]

Politicians and editorial writers around the country have all weighed in with their views about what ought to be done.[9] Inevitably, proposals for tort reform have appeared, at both the federal and state levels.[10] None of this is new, of course. It all happened in the mid 1970s, and, to

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[5] See, e.g., American College of Obstetricians and Gynecologists, News Release, *Medical Liability Survey Reaffirms More Ob-Gyns Are Quitting Obstetrics*, July 16, 2004, www.acog.org/from_home/publications/press_releases/nr07-16-04.cfm (site visited November 29, 2004); Kathleen Kerr, *Docs Don't See Future in Babies; Long Island Obstetricians Seek Support for Legislative Reform of Malpractice Insurance System*, NEWSDAY, A6, October 19, 2004.

[6] Three of the twenty states placed on the "crisis" list maintained by the AMA. See www.ama-assn.org (site visited December 23, 2004).

[7] Studdert et al. 2004a, *supra* note 2, at 286; Michelle M. Mello et al., *Caring for Patients in a Malpractice Crisis: Physician Satisfaction and Quality of Care*, HEALTH AFFAIRS 23:4, 41, at 47 (2004) (hereinafter Mello et al. 2004); Sage, *supra* n.2, at 20.

[8] Michelle M. Mello and Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L.REV. 1595, 1616 (2002) (hereinafter Mello and Brennan 2002); PAUL WEILER, MEDICAL MALPRACTICE ON TRIAL 76-77 (1991) (hereinafter WEILER 1991). There is some indication, however, that the long-standing of practice of charging one premium for all physicians practicing in the same specialty, such as general surgeons, or Ob-Gyns, is changing. See David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (If Anything) Should We Do About It?* 80 TEX. L.REV. 1639, 1645 at n.18 (2002).

[9] See, e.g., John P. McDaniel, *Triage for a Crisis in Care*, WASHINGTON POST, November 21, 2004 (editorial); Jack Torry, *Bush Slams Malpractice Lawsuits*, COLUMBUS DISPATCH, A1, October 23, 2004; Bob Herbert, *Malpractice Myths*, NEW YORK TIMES, June 21, 2004 (editorial).

[10] Several states (Florida, Idaho, Mississippi, Ohio, Oklahoma, Texas and West Virginia) enacted cap legislation in 2003 and 2004, limiting the amount of non-economic damages a medical malpractice plaintiff may recover, along

an extent, the mid 1980s. The fact that a third crisis appeared in the early 2000s speaks volumes about the effectiveness of the various proposals and reforms adopted in the past.

To this picture must be added another factor, hardly surprising in itself, but one that should not be overlooked. Physicians have little use for the tort liability system as it operates in the United States. One need only skim the AMA's website[11] for a quick sense of this. Physicians consistently over-estimate their chances of being sued.[12] In a recent randomized survey of Pennsylvania medical specialists, 80% of the respondents characterized their malpractice insurance premiums as either an "extreme burden" or a "major burden."[13] But beyond the obvious fact that doctors distrust the tort system in this country, there is a more basic concern. Physicians as a group doubt the ability of any finder of fact- be it judge, jury, or lawyer- to determine whether their conduct- their diagnosis, their treatment, their care in general- was negligent.[14] In fact, it goes deeper than this. Many physicians are offended by the very idea that a non-physician might pass judgment as to their medical decisions.[15] It is not enough to acknowledge that "physicians are upset" and then concentrate one's efforts solely on the economic aspects of the problem. There is more to it than that. For any "reform" to have any

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with various other changes. In contrast, in 2004 voters in Oregon and Wyoming defeated ballot initiatives to impose caps on non-economic damages. Meanwhile, Florida voters approved a constitutional amendment limiting attorneys' fees in medical malpractice cases. See Tanya Albert, *State Tort Reform Ballot Wins Set Stage For Further Battles,*AMEDNEWS.COM, November 22, 2004. At the federal level, the House of Representatives passed H.R. 4280, the Health Act, in May 2004. One of the key features of the bill was the imposition of a cap on non-economic damages. The Senate, to date, has not approved the bill.

[11] www.ama-assn.org.

[12] Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued,* 17 J. Health, Politics, Policy and Law 463, 475 (1992).

[13] Mello et al. 2004, *supra* n.7, at 48.

[14] Ralph Peeples et al., *Settlement Has Many Faces: Physicians, Attorneys, and Medical Malpractice,* 41 J. HEALTH & SOCIAL BEHAVIOR 333, 342-43 (2000) (hereinafter Peeples et al. 2000); PAUL WEILER, A MEASURE OF MALPRACTICE (1993) (hereinafter WEILER 1993a), at 126-129; Catherine T. Struve, *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options,* at 7 (2003) (hereinafter Struve), available at www. Medliabilitypa.org/research/struve1003.

[15] Timothy Marjoribanks et al., *Physicians' Discourse on Malpractice and the Meaning of Medical Malpractice,* 37 J. Health & Social Behavior 163, 167 (1996); Struve, *supra* n. 14, at 16.

chance of long-term success, the concerns of physicians- as well as their patients- must be acknowledged and addressed.

II. What We Know

It is a paradox that while we actually know quite a bit about medical malpractice, we know very little about what might work to fix it. More so than most other types of personal injury torts, medical malpractice has consistently attracted scholarly attention. Of equal importance, this scholarly attention has often taken the form of empirical studies, based on actual observation, as opposed to case and statutory analysis, or mere theoretical discourse. Thus we know that most incidents of medical negligence never form the basis for a claim against the physician, the hospital, or the insurer, much less a civil lawsuit.[16] Every study on the subject leads to the same conclusion: much more medical negligence takes place than most people think.[17] On the other hand, a large number of ill-founded claims of medical negligence are made every year, as well.[18] Thus, the problem is one of both under-inclusion and over-inclusion.

When lawsuits are filed, the evidence strongly suggests that the tort liability system does a good job of identifying meritorious cases (i.e., those cases involving negligence on the part of the physician), although the identifying and the compensating is typically done in a very inefficient and costly way.[19] Almost all empirical studies have found that compensation is related to a determination of negligence on the part of the defendant physician. Thus, Danzon examined

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[16] PATRICIA M. DANZON, MEDICAL MALPRACTICE 19-29 (1985) (hereinafter DANZON 1985) (California data); WEILER 1993a, at 137-39 (New York State data, as part of the Harvard Medical Practice Study); David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L.REV. 1643, 1675, 1682 (2000)(hereinafter Studdert et al. 2000). See, generally, the summary provided in Patricia Danzon, *Liability for Medical Malpractice*, in CULYER AND NEWHOUSE, eds., HANDBOOK OF HEALTH ECONOMICS 1339, 1351-55 (2000) (hereinafter Danzon 2000).

[17] This was one of the key points made by the Institute of Medicine report in 2000. See INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (1999)(Kohn, Corrigan and Donaldson, eds.). See also Mello and Brennan 2002, *supra* n.8, at 1599-1603; Hyman, *supra* n. 8 at 1643 (2002).

[18] WEILER 1993a, *supra* n.14 at 71.

[19] Studdert et al. 2004a, *supra* n. 2 at 285.

malpractice claims closed by California insurers in 1974 and 1976, and concluded that in general, the malpractice liability system operated in a rational way. Meritorious claims were more likely to be paid than non-meritorious claims.[20] Cheney, et al. reviewed closed insurance company claims relating to anesthesiologists and found a clear connection between negligence and compensation.[21] Looking at over 8000 closed insurance files from New Jersey, and examining the assessments of physician reviewers in those cases, Taragin et al. also found that claims were much more likely to be paid if the physician reviewers felt the defendant doctor's conduct had fallen short of the relevant standard of care.[22] Farber and White reported similar findings, after a review of medical hospital records relating to 242 malpractice lawsuits,[23] as did Sloan et al. following a study of obstetrics and emergency malpractice claims in Florida.[24] Indeed, only one study- although probably the one most often cited- did *not* find a connection between medical negligence and compensation. That study, which was based on a review of approximately 57 hospital records, instead found only a connection between severity of injury and compensation.[25] The connection between negligence and compensation can be shown not only in insurance company practice (paying only claims deemed meritorious, on the opinion of expert physician reviews)[26] but also with the ultimate arbiter in this area- the lay jury.[27]

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[20] DANZON 1985, *supra* n. 16 at 50.
[21] Frederick W. Cheney et al., *Standard of Care and Anesthesia Liability,* 261 JAMA 1599, 1601 (1989).
[22] Mark I. Taragin et al., *The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims,* 117 ANNALS INTERNAL MED. 780, 781 (1992).
[23] Henry Farber and Michelle White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice,* 23 J. LEGAL STUD. 777 (1994).
[24] FRANK A. SLOAN et al., SUING FOR MEDICAL MALPRACTICE, 170-75 (1993) (hereinafter SLOAN et al. 1993); Frank A. Sloan and Chee Ruey Hsieh, *Injury, Liability, and the Decision to File a Medical Malpractice Claim,* 29 LAW & SOC'Y REV. 413 (1995); Frank A. Sloan and Chee Ruey Hsieh, *Variability in Medical Malpractice Payments: Is the Compensation Fair?* 24 LAW & SOC'Y REV. 997,1025-27 (1990).
[25] Troyen A. Brennan et al., *Relation Between Negligent Adverse Events and the Outcomes of Medical Malpractice Litigation,* 335 NEW ENG. J. MED. 1963, 1965 (1996). The authors subsequently acknowledged the singularity of their findings. See Studdert et al. 2000, *supra* n.16, at 1654.
[26] Ralph Peeples et al., *The Process of Managing Medical Malpractice Cases: The Role of Standard of Care,* 37 WAKE FOREST L.REV 877, 883-85 (2002) (hereinafter Peeples et al., 2002).

It appears that lay juries do "get it right" most of the time- their lack of medical training notwithstanding.

Most medical malpractice lawsuits never reach trial, although the trial rate for medical malpractice cases is consistently higher than the trial rate for other civil lawsuits.[28] The most common disposition is settlement. Approximately half of all medical malpractice lawsuits are settled prior to verdict.[29] Unilateral abandonment of the case by the plaintiff- i.e., a voluntary dismissal, not involving the payment of money- is also quite common.[30] When a medical malpractice case does go to trial, the defendant physician prevails most of the time- a result which recurs in the literature. [31] While a number of explanations for this pattern at trial are possible (e.g., general jury bias in favor of physicians, better expert witnesses, or greater defense resources) the most likely reason is more basic. Insurers settle cases they believe they will lose. They try only those cases they believe they can win.[32] The insurer's assessment is usually borne out at trial. Thus, in a real sense, a plaintiff who takes her medical malpractice case all the way to trial has already lost: if she has been unsuccessful in coaxing a settlement from the insurer, the

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[27] Taragin et al., *supra* n. 22; Neil Vidmar, *The Performance of the American Civil Jury: An Empirical Perspective,* 40 ARIZ. L.REV. 849, 859 (1998).

[28] Vidmar, *supra* n. 27, at 851; Samuel Gross and Kent Syverud, *Getting To No: A Study of Settlement Negotiations and the Selection of Cases for Trial,* 90 MICH. L.REV. 319, 364 (1991); Thomas B. Metzloff, *Resolving Malpractice Disputes: Imaging the Jury's Shadow,* 54 LAW & CONTEMP. PROBS. 43, 49 (1991).

[29] SLOAN et al. 1993, *supra* note 24 at 167; DANZON 1985, *supra* n. 16 at 32, 42; Peeples et al 2002, *supra* n. 26 at 881.

[30] SLOAN et al. 1993, *supra* note 24 at 176; DANZON 1985, *supra* n.16, at 42.

[31] Studdert et al.2004a, supra n. 2, at 285.The reported rates vary according to the sample studied, but the results uniformly indicate a success rate in excess of 50% for defendant physicians, and usually significantly higher than that. For example, Jury Verdict Research reported that defendant physicians prevailed 58% of the time in 2002. JVR News Release, April 1, 2004, at www. juryverdictresearch.com (visited October 16, 2004). Weiler has estimated a defense win rate of 67%, Paul Weiler, *The Case for No-Fault Medical Liability,* 52 MD. L.REV. 908, 914 (1993) (hereinafter Weiler 1993b). Sloan and Hsieh reported a rate of about 75% (Florida). Sloan and Hsieh 1990, *supra* n. 24 at 1007. A recent study of California verdicts by the RAND Institute for Civil Justice reported a defense win rate of about 78%, as compared to a 47% defense win rate for all other trials during the same period. Nicholas Pace et al., *Capping Non-Economic Awards in Medical Malpractice Trials,* RAND Institute for Civil Justice (2004) 19 (hereinafter Pace et al. 2004). Metzloff reported a rate of 81% (North Carolina). Metzloff, *supra* n. 28 at 50. For the years 1985-1998, the Physician Insurers Association of America (the PIAA) reported a defense "win" rate at trial of 81%. Physician Insurers Association of America, *Medical Malpractice Claim Expenses* 2 (1999) (hereinafter "PIAA"). See also Gross and Syverud, *supra* n. 28 at 362-67.

[32] Peeples et al.2002, *supra* n. 26, at 889, 891.

chances are excellent that she will be unsuccessful with the jury as well. Her attorney has also lost, most likely. Medical malpractice cases are always taken on a contingency basis. The percentages may vary (between 20 and 50%, with 33 1/3 % being the most common)[33] but the basic truth does not change: the plaintiff's lawyer is paid only if money is recovered from the defendant's insurer.

Medical malpractice is in effect a specialty practice, although more so on the defense side than on the plaintiffs' side. Defense lawyers are retained and paid by the malpractice insurer.[34] The insurer typically uses a relatively small number of lawyers to represent its insureds.[35] As a result, defense lawyers are usually highly experienced "repeat players."[36] Defense lawyers are usually paid on an hourly basis, although various incentive agreements are occasionally used. In exchange for the assurance of a certain volume of work, defense lawyers often agree to a discount from their standard hourly rate.

Any lawyer admitted to practice can be a malpractice plaintiff's lawyer. All that is needed is a willing client. Thus, the level of sophistication among plaintiffs' lawyers varies from the inexperienced to the well seasoned. The costs involved in bringing a medical malpractice lawsuit are substantial. Medical records must be read and reviewed. The initial reviewing must be done by someone with a medical background of some sort- either by in-house staff, or by a paid consultant. Physicians who treated the plaintiff, other than the defendant(s), often will need

[33] Herbert M. Kritzer, *The Wages of Risk: The Returns of Contingency Fee Legal Practice,* 47 DePAUL L.REV. 267, 285 (1998) (hereinafter Kritzer 1998a); SLOAN et al.1993, *supra* n. 24, at 77.
[34] Gunnar, *supra* n.3 at 479-80; Peeples et al.2002, *supra* n. 26, at 880.
[35] Peeples et al.2002, *supra* n. 26, at 880.
[36] Marc Galanter, *Why the"Haves" Come Out Ahead: Speculation on the Limits of Legal Change,* 9 LAW & SOC'Y REV. 95, 114 (1974). See also Joel Grossman et al., *Do The "Haves" Still Come Out Ahead?"* 33 LAW & SOC'Y REV. 803 (1999); Samuel Gross and Kent Syverud, *Don't Try: Civil Jury Verdicts in a System Geared to Settlement,* 44 U.C.L.A. L.REV.1, 53 (1996).

to be identified and interviewed. Expert witnesses[37] must be identified and retained- and they, too, will need to review the medical records. Usually at least several depositions will be necessary: that of the defendant(s), and at least the key defense experts. Depositions of other witnesses, such as subsequent treating physicians or members of the defendant's office staff, are not uncommon. Furthermore, the defense will almost always depose the plaintiff as well as the plaintiff's experts. Most observers estimate the cost of preparing a medical malpractice case at a minimum of $50,000. Depending on the complexity of the case, the pretrial costs can easily run much higher.[38] If the case actually goes to trial, substantial additional expenses must be added to the total cost. The high entry cost of medical malpractice lawsuits thus means that in practice, damages of at least $100,000 must be involved, in order to make bringing the case "worthwhile."[39]

It is an expensive business, with high risks for the plaintiff's lawyer. Not only is there the risk of never being paid for the time expended; it is often the case that the plaintiff's lawyer advances the costs of pre-trial preparation, with little expectation of recovering those funds, unless money is obtained from the defendant either in settlement or at trial.[40] It is not surprising,

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[37] Expert testimony from other physicians is a fixture of most medical malpractice litigation. Expert witnesses are used to testify as to the relevant standard of care to which the defendant physician should be held, and, to a lesser extent, as to causation of the alleged injury. See, generally, William Meadow, *Operationalizing the Standard of Medical Care: Uses and Limitations of Epidemiology to Guide Expert Testimony in Medical NegligenceAllegations,* 37 WAKE FOREST L.REV. 675, 676 (2002); Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium,* 57 WASH. & LEE L.REV. 163 (2001).

[38] See, e.g., Richie Kemp, *When Attorneys Come Back for Seconds: Increased Attorney Fees for Extraordinary Work in Medical Malpractice Cases,* 25 J. LEGAL MED. 79 , 89-90 (2004) ("between $50,000 and $100,000 to prepare and litigate the average medical malpractice action"); Gary T. Schwartz, *Empiricism and Tort Law,* 2002 U. ILL. L. REV. 1067, 1071 ("the cost of mounting a plausible malpractice claim is at least $50,000"); see also Gail B. Agrawal and Mark A. Hall, *What If You Could Sue Your HMO? Managed Care Liability Beyond the ERISA Shield,* 47 ST. LOUIS U.L.J. 235, 247 (2003); Stephen Daniels and Joanne Martin, *It Was the Best of Times, It Was the Worst of Times: The Precarious Nature of Plaintiffs' Practice in Texas,* 80 TEX. L.REV. 1781, 1798 (2002).

[39] Schwartz, *supra* n. 38, at 1071; Gary T. Schwartz, *Medical Malpractice, Tort, Contract, and Managed Care,* 1998 U.ILL.L.REV. 885, 895; NEIL VIDMAR, MEDICAL MALPRACTICE AND THE AMERICAN JURY, 61(1995) (hereinafter VIDMAR 1995). Almost twenty years ago, a GAO report estimated the damages threshold at $50,000. General Accounting Office, *Medical Malpractice: A Framework for Action,* GAO/HRD-87-73 at 23 (1987).

[40] Kritzer 1998a, *supra* n. 33, at 270; Daniels and Martin, *supra* n. 38, at 1812; Kemp, *supra* n. 38, at 89-90.

then, that there are lawyers who specialize in medical malpractice litigation. Because of the pervasiveness of the contingent fee, their success is largely a function of the cases they handle.[41] Their ability to attract good cases, due to their own reputation, as well as their ability to obtain referrals from other attorneys are of obvious importance.[42] Ultimately, however, the success of a plaintiff's medical malpractice lawyer is a function of his or her case-picking ability.[43] A case of likely liability, but involving only limited recovery (such as a case where appendicitis was diagnosed later than it should have been, but the patient suffered little or no permanent harm) may not be worth pursuing. The amount of time and money needed to prepare the case, compared to the amount that can be recovered, will make it unlikely that an experienced plaintiff's lawyer would want to take the case. A case of very uncertain liability, but involving potentially high damages, might offer some allure, but unless there is a reasonable chance of a large recovery, an experienced attorney will likely decline to take that case as well. After all, one-third of zero is still zero. In fact, specialist plaintiff's attorneys can be compared to portfolio managers.[44] Some cases will yield a recovery, and some will not; certainty of outcome is never a part of the plaintiff's lawyer's practice. The key is to pick cases that offer a range of recoveries, both in terms of dollar value and likelihood of success. In short, the plaintiffs' lawyers who succeed are the ones who are adept at picking good cases. However, there is also a catch: because of the possible effect of a plaintiff's lawyer's reputation, a case in the hands of a well-known and respected attorney may be worth much more than the same case in the hands of a novice attorney.

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[41] Studdert et al.2004a, *supra* n2, at 284; Daniels and Martin, *supra* n. 38, at 1823.
[42] Daniels and Martin, *supra* n.38, at 1793-94; SLOAN et al.1993, *supra* n.24, at 75-76.
[43] See, e.g., Herbert M. Kritzer, *Seven Dogged Myths Concerning Contingency Fees*, 80 WASH. U.L.Q. 739, 754, 772-73 (2002) (hereinafter Kritzer 2002).
[44] Kritzer 2002, *supra* n. 43 at 754; see also Neil Vidmar and Leigh Anne Brown, *Tort Reform and the Medical Liability Insurance Crisis in Mississippi: Diagnosing the Disease and Prescribing a Remedy*, 22 MISS. C.L.REV. 9, 32 (2002).

The claims resolution process, especially when a lawsuit is filed, is usually slow and expensive for all involved.[45] A very high percentage- in excess of 55%- of premium dollars are used to pay the "overhead" of attorneys' fees, expert reviews, and trial preparation expenses, to say nothing of the amount of money spent by the insurer internally.[46] As a means of compensating injured patients, the claims resolution process is grievously inefficient for all concerned.[47]

For all that we do know about medical malpractice, some questions remain unanswered. Only limited reliable data is available, for example, on the typical allocation (if there is such a thing) in a jury award between economic and non-economic damages.[48] In many states, jurors are simply not instructed to make such a determination: damages are just damages. In states where jurors are instructed to make an allocation between economic and non-economic damages (for purposes of complying with a statutory cap on damages, or otherwise) data has not been rigorously collected and analyzed until quite recently. For the most part, those efforts have been limited to a single state- California.[49] It follows, then, that even less information is available about economic and non-economic damages, when cases are settled. Compounding the problem is the fact that confidentiality is a condition of many negotiated settlements.[50]

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[45] Sage, *supra* n. 2 at 29; Daniels and Martin, *supra* n. 38, at 1798; Weiler 1993b, *supra* n. 31 at 916.
[46] Studdert et al. 2004a, *supra* n.2 at 285-86; Stephen D. Sugarman, *Doctor No,* 58 U. CHI. L.REV. 1499, 1502-03 (1991). The high level of overhead is not unique to medical malpractice claims. A study conducted by Tillinghast-TowersPerrin in 2003 concluded that less than 50% of premium dollars goes to compensate injured people. Tillinaghast-TowersPerrin, *U.S. Tort Costs: 2003 Update,* at 17.
[47] Hyman, *supra* n.8, at 1644; Weiler 1993b, *supra* n.31 at 926.
[48] Extrapolating from the data derived from the Harvard Medical Practice Study (and as reported by WEILER 1991, *supra* n. 8, Sugarman estimated that only 10-15% of malpractice premium dollars actually goes to compensate for out-of-pocket economic losses. Sugarman, *supra* n.46, at 1503.
[49] See, e.g., Nicholas Pace et al.2004, *supra* n.31.
[50] Nonetheless, confidentiality can not always be assured. For example, New Jersey now requires the on-line public posting of payments made by insurers on behalf of physicians in medical malpractice cases. See N.J.S.A. §45:9-22.23. See Mary P. Gallagher, *Online Posting of Med-Mal Payouts is Seen as Chilling Settlements,* NEW JERSEY LAW JOURNAL, November 17, 2004.

We also do not know much about experts. Is it true that two are better than one, and that four are better than two? Is it important to have more experts than the other side? Are in-state experts better than out-of-state experts? Many lawyers assume they know the answers to these questions- but few assumptions about the use of experts have ever been tested empirically. Credible studies are not easy to find.[51] There is reason to believe, however, that experts drawn from the same specialty will frequently disagree with one another, even when reviewing the same medical records.[52]

III. The Problem

Knowing all this about the claims resolution process, why is it that crises seem to occur with such annoying frequency? One answer, advanced by critics of the insurance industry, is to blame the problem on the insurance companies.[53] When income from the investment of premium *revenues* is robust, insurers price their policies aggressively, in an effort to expand market share; when income from investment of premium revenue declines (and losses from claims begin to increase) the industry increases the rates it charges, and blames the increase on the spiraling level of indemnity payments made to claimants and their attorneys.[54] Another answer is to argue that, in fact, the amount of money paid out in claims and in the defense of those claims has been rising dramatically; and so, rate increases are inevitable.[55] It is a debate that generates more heat than light. Simple answers are not to be expected. It seems unlikely that a single cause for the

[51] See, however, VIDMAR 1995, *supra* n.39 at 72-76 for a useful discussion of the role expert witnesses play in medical malpractice litigation; see also Neil Vidmar and Shari Diamond, *Juries and Expert Evidence,* 66 BROOKLYN L.REV. 1121 (2001).
[52] K.L. Posner et al., *Variation in Expert Opinion in Medical Malpractice Review*, 85 ANESTHESIOLOGY 1049-1054 (1996).
[53] See, e.g., Zimmerman and Oster, *supra* n. 4; J. Robert Hunter and Joanne Doroshow, *Premium Deceit* (1999), available at www.centerjd.org/PremiumDeceit/%20.pdf.
[54] See Americans for Insurance Reform, *Medical Malpractice Insurance: Stable Losses/Unstable Rates 2004*, available at www.insurance-reform.org.
[55] See, e.g., American Medical Association, *supra* n. 2 at 2-4 (2004).

problem exists. Instead, a combination of factors, including a steady increase in claims severity[56] and a drop in insurance industry investment income over the past several years seems to be at fault.[57] What seems true, regardless of the cause of the crisis, is that few people are well served by the existing system: certainly not patients or physicians, and perhaps not plaintiffs' lawyers, defense lawyers, or insurers. Most victims of medical negligence never seek redress- either by filing a claim, or by filing a lawsuit.[58] Thus, most injuries go uncompensated. Physicians are caught in the middle. Either they are being manipulated by their insurers, or they are being manipulated by dissatisfied patients and plaintiffs' attorneys. Plaintiffs' lawyers typically find themselves vilified as rapacious opportunists, while defense counsel are seen as a necessary (but still regrettable) evil.

The point here is not that medical malpractice law as it is practiced today fails because the premiums doctors have to pay are too high, or because doctors do not trust the tort liability system. Those two observations are symptoms of a larger failing. Judged by either of the two fundamental goals of modern tort law- deterrence and compensation[59]- the medical malpractice system is a failure, for most of the people, most of the time.

There are many reasons to believe that as a system of deterrence, medical malpractice law does not work. For deterrence to work, a wrongful behavior must be identified, and a punishment must be imposed. In order to alter his or her behavior, the wrongdoer must know what it was he or she did wrong- and must know what the consequences will be of behaving wrongfully in the future. While doctors who are sued for malpractice usually know what it is they are alleged to have done wrong, it is not often the case that they agree with the ultimate

[56] "Claims severity" refers to the amount of compensation demanded and/or recovered by a claimant.
[57] Thorpe, *supra* n.2, at 21; GAO *Multiple Factors, supra* n.3, at 43-45.
[58] See text accompanying notes 16-17, *supra*.
[59] DAN B. DOBBS, THE LAW OF TORTS §§10, 11 at 17-19(2000); W. PAGE KEETON et al., PROSSER AND KEETON ON THE LAW OF TORTS, 5th ed. §4 at 20-26 (1984).

determination of liability if such an adverse determination is made. [60] It does not matter if the adverse determination is made by a jury at trial or by the physician's own insurer who chooses to settle the case. At bottom is the conviction that no layman has the training or insight to judge a physician's medical decisions or behavior.[61] Even if the jury actually gets it "right" that fundamental conviction remains. There is some irony to this: one of the key ways that an insurer will make a determination about liability is to send the relevant complaint and medical records to other physicians practicing in the same specialty for review. Only when the consensus of the outside reviewers indicates a serious problem, will an insurer seek a settlement.[62] Thus, peer review does routinely happen- except that it's usually anonymous and almost never involves direct communication between reviewer and reviewed. Beyond these behavioral observations, there is the fact that when compensation is paid, it is paid by the insurer. Rarely is any portion of an award or settlement actually paid by the physician.[63] It should come as no surprise, then, that efforts to identify a meaningful deterrence effect produced by the malpractice liability system have not been successful.[64]

Judged against the goal of compensation- where only meritorious claims would be paid; and where the amounts paid would bear a consistent, logical connection to the type of injury sustained – the medical malpractice system fails badly. There are problems of erroneous compensation (paying the wrong claimants); of erroneous non-compensation (not paying patients injured by medical negligence); of overpayment; and of underpayment.

[60] Peeples et al. 2000, *supra* n.14, at 341-42.
[61] Vidmar, *supra* n. 27, at 858. See also notes 14-15, *supra.*
[62] Peeples et al.2002, *supra* n.26, at 886.
[63] Although deductibles are not commonly used in medical malpractice insurance, it is possible that one or more adverse events might induce an insurer to either refuse to renew coverage, or require a higher premium in the future. This rarely happens in practice, however.
[64] Mello and Brennan 2002, *supra* n.8, at 1607-9; Hyman, *supra* n.8, at 1644.

Erroneous compensation.

Not all claimants who receive compensation deserve it. This concern can be heard anywhere personal injury claims are defended; it is not unique to medical malpractice. There is substantial empirical evidence that indicates erroneous compensation is not uncommon in medical malpractice cases.[65] Nonetheless, the incidence of successful "false" claiming does not seem excessive. What does not seem to happen very often are strictly "nuisance" payments. Most professional liability insurers insist on a showing of at least potential liability before payment will be discussed.[66]

Erroneous non-compensation.

Several major studies within the past twenty years indicate that the incidence of medical negligence far exceeds the rate at which injured patients claim compensation for such injuries. Most victims of medical negligence never assert a claim, much less file a lawsuit. One obvious reason for this is the high entry costs of medical malpractice litigation.[67]

Beyond these concerns of simply paying the right cases, there is also the problem of the close case. Not all cases are clear cut on the issue of negligence. Experts often disagree, simply as to what the standard of care requires.[68] Given the fact that experts are hired either by the plaintiff or the defendant, this should not be surprising.

An additional problem is the simple fact that the claims resolution process is an adversarial system. Factors other than medical negligence can influence the outcome- such as the

[65] See, e.g., Cheney et al., *supra* n.21, at 1601 (in 42% of cases studied, payment made even though care provided was deemed within the standard of care); Taragin et al., *supra* n. 22, at 781 (compensation paid in 21% of cases deemed defensible by the insurer); Brennan et al, *supra* n. 25, at 1965-66 (compensation is predicted by severity of injury, not medical negligence).

[66] For example, as reported by the Physicians' Insurers' Association of America (the PIAA), in 2002 almost 70% of all claims filed against physicians were closed without any payment. See American Medical Association, *supra* n.2, at 2-3; Peeples et al. (2002), *supra* n.26 at 886.

[67] See the authorities cited at notes 16-17, *supra*; see also text accompanying notes 38-39, *supra*.

[68] See Peeples et al.2002, *supra* n.26, at 884; K.L. Posner et al., *supra* n. 52.

disparate skill levels of the attorneys, the polish of one party's experts, the relative attractiveness of the plaintiff and the defendant, as well as the makeup of the jury.[69]

Under and Overpayment.

Compensation is not a simple "yes or no" proposition. A $5000 payment in settlement of a claim for a permanent, debilitating injury is unlikely to represent adequate compensation, just as a payment of $500,000 for a simple delay in the diagnosis of appendicitis is likely to represent over-compensation. Although "lottery" type awards are not unheard of (and are invariably widely publicized), most research suggests that at least in medical malpractice, claimants are typically under-compensated.[70]

The problems of erroneous compensation, non-compensation, and over and underpayment can also be seen easily enough in other areas of personal injury litigation.[71] Claiming rates may vary by type of injury (e.g., automobile vs. hospital), but the problems of erroneous compensation and erroneous non-compensation are not unique to medical malpractice litigation. The puzzle of damages- how they should be calculated; what factors should be included, and who should do the calculating- is a problem common throughout tort law.[72] Ultimately, a claimant's damages are whatever amount, if any, the jury awards, or that he or she is willing to accept in settlement. It is a land populated by rules of thumb and multipliers but few if any guidelines. Even one of the more well-known "rules of thumb"- that total damages should equal some multiple (often either two or three) of "special" (i.e., economic) damages does not

[69] This phenomenon- that factors other than the existence of medical fault can influence outcomes- has been occasionally noted in the literature, but seldom studied. See, e.g., Brennan et al., *supra* n.25, at 1966; SLOAN et al. 1993, *supra* n.24, at 183-85.
[70] Sage, supra n.2, at 29; SLOAN et al. 1993, *supra* n.24, at 206-7; Weiler 1993b, *supra* n.31, at 918.
[71] See, e.g., the discussion in SLOAN et al.1993, *supra* n.24, at 187-188.
[72] See, e.g., Studdert et al., *Are Damage Caps Regressive? A Study of Malpractice Jury Verdicts in California*, 23 HEALTH AFFAIRS 54, 55 (2004) (hereinafter Studdert et al 2004b).

seem to be borne out in practice.[73] Indeed, plaintiffs' lawyers themselves often disagree on what a case is worth.[74] In an off-the-rack world, damage awards defy uniformity. Medical malpractice awards are no exception.[75]

Medical malpractice litigation points up another failure of the goal of compensation, however. Medical malpractice claims, once they become lawsuits, are almost always expensive for both sides.[76] Expressed in premium dollar terms, most researchers estimate that 40% of every premium dollar is spent on litigation-related expenses, primarily legal fees. Of this percentage, about half can be attributed to plaintiffs' lawyers and about half to defense counsel. [77] In addition to the predictable legal fees and the usual discovery costs that will be incurred, both plaintiff and defendant will have to spend money on experts. It is rare that a claim or a defense can be made without the use of expert testimony, as to standard of care and as to causation. State law rarely imposes any limitations on the number of experts that may be identified for possible use at

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[73] Herbert M. Kritzer, *Contingent-Fee Lawyers and Their Clients: Settlement Expectations, Settlement Realities, and Issues of Control in the Lawyer-Client Relationship*, 23 LAW & SOC. INQUIRY 795, 817-18 (1998) (hereinafter Kritzer 1998b).

[74] Two of the more famous studies are by Douglas Rosenthal, LAWYER AND CLIENT: WHO'S IN CHARGE (1974) and Gerald Williams, LEGAL NEGOTIATION AND SETTLEMENT (1983). See the discussion in Kritzer 1998b, *supra* n.73, at 817.

[75] A number of researchers, reviewing jury verdicts, have noted serious "horizontal equity" problems: compensation for the same or similar injury can vary greatly, from claimant to claimant. See, e.g., Sloan and Hsieh 1990, *supra* n.24, at 1026; Studdert, et al. 2004b, *supra* n.72, at 56. See also Kirk B. Johnson et al., *A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*, 42 VAND. L.REV. 1365, 1369 (1989).

[76] A 2003 Report prepared by the U.S. Department of Health and Human Services estimated the average cost of defending claims that settled in 2001 was $39, 819 (using data provided by the PIAA, the Physician Insurers Association of America). U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Reforming the Medical Litigation System to Improve the Quality of Health Care* at 12 (2003). A previous report prepared by HHS estimated the average cost of defense, for all claims, settled or not, at $24,000. U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System* at 8 (2002), available at aspe.hhs.gov/daltcp/reports/litrefm.htm. The largest insurer of physicians in North Carolina, Medical Mutual Insurance Company of North Carolina, has reported an average defense cost per claim of $22,544, for 1848 claims filed, since 1976 to 2003. David Sousa, *NC Medical Malpractice Insurance Data v. Plaintiffs' Attorneys: Can Fact Prevail Over Fiction?* 64 NC MED J 182, 185 (2003).

[77] Danzon 2000, *supra* n.16, at 1369; WEILER 1991, *supra* n.8 at 53, 192 n.28. A study conducted by Tillinghast-TowersPerrin, examining tort costs in general estimated defense costs at 14% of the total amount. Tillinghast-TowersPerrin, *supra* n.46, at 17.

trial.[78] As a result, "more is better" often dominates each side's case preparation. In this particular arms race, however, the defense has the advantage. It remains true that recruiting defense experts, particularly those who practice within the state, is much easier than recruiting plaintiff's experts.[79] Regardless of who retains them, the services of experts do not come cheap. Hourly rates of several hundred dollars for reviewing medical records or testifying at deposition are common. Even higher rates for trial testimony are also quite common.[80]

In short, the malpractice liability system does a poor job of compensating injured patients, and it requires a high level of overhead to operate. There is little reason to think that the goal of deterrence is any better served. It is a woefully inefficient system badly in need of repair.

IV. What Has Been Tried

Certainly many kinds offixes have been tried. Even more have been proposed, and not tried. The more frequently tried reforms have included the imposition of statutory limits on the amount of damages that may be awarded to a successful plaintiff ("caps"); the use of pre-suit or pre-trial screening panels (mandatory and voluntary); abolition or modification of the "collateral source rule;"[81] a requirement that prior to filing suit, the plaintiff's attorney certify in some way that he or she has consulted with a medical expert who will support the allegations of the

[78] Virginia is a notable exception. See VA. CODE ANN. §8-01.581.20(C). (Each party limited to using no more than two experts per medical discipline, on any issue presented.)

[79] In addition, there is the perceived threat of professional sanctions being invoked against physicians who testify in favor of plaintiffs. To date, the threat is more perceived than real. However, there are recent instances of professional discipline being imposed on physicians who testify for plaintiffs (on the grounds that their testimony is at odds with the prevailing standard of care). See, e.g., Austin v. American Ass'n. of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001)(opinion by Posner, J.); Fred Cohen, *The Expert Medical Witness in Legal Perspective*, 25 J. LEGAL MED. 185 (2004); Theresa DiPaola et al., *Silence of the Experts*, 40 TRIAL 20 (Oct. 2004).

[80] Ten years ago, Vidmar estimated typical expert witness fees as ranging between $300 and $500 per hour. VIDMAR 1995, *supra* n. 39, at 60, 74. Vidmar's estimates were based on his observations of North Carolina cases. Following extensive conversations with both plaintiff's and defense lawyers in North Carolina in 2004, I believe the "going rate" for expert review and testimony has at least doubled since that time.

[81] The collateral source rule excludes from the jury's consideration the existence of other sources of insurance or other compensation (such as medical insurance, or workers' compensation) available to the injured party.

complaint; and various types of ADR, primarily arbitration and mediation.[82] Heightened regulation of malpractice (and other) insurers has also been occasionally tried.

There are, of course, other proposals that have never been tried, at least not on a serious scale. The most prominent of these include various no-fault proposals,[83] in which the emphasis would be on compensation in the presence of an undesirable outcome due to medical intervention, rather than in the presence of medical negligence. Various changes directed at the judicial system itself have also been proposed, including the creation of a specialty court which would hear and determine only cases alleging medical malpractice;[84] or a resort to special juries, in which the jury pool would be limited to those with medical degrees;[85] or an administrative, fault-based system that would replace the trial court.[86] Like no-fault, these ideas have attracted few adherents outside the academy.

Of the various reforms that have actually been tried, the two most sweeping in their potential effect are the imposition of damage caps and the use of screening panels. The history of both these reforms has been checkered. In a number of states, these reforms have been declared unconstitutional by the courts.[87] Furthermore, assessing the success of these reforms has proved difficult for at least two distinct reasons. First, no two states have done it exactly the same way.

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[82] See, generally, the compilation provided by the National Conference of State Legislatures, at www.ncsl.org/programs/insur/medliability.pdf. (visited December 23, 2004).

[83] See, e.g., Mello and Brennan 2002, *supra* n.8, at 1626-27; David Studdert and Troyen Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217 (2001); Randall R. Bovbjerg and Frank A. Sloan, *No-Fault for Medical Injury: Theory and Evidence*, 67 U.CIN.L.REV. 53 (1998); Weiler 1993b, *supra* n.31; Jeffrey O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims By Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U. L.REV. 589, 615-16 (1982).

[84] See Struve, *supra* n 14, at 68-70; Lindsay Fortado, *States Weigh 'Med-Mal' Courts*, NATIONAL LAW JOURNAL, December 13, 2004; Philip K. Howard, *The Best Course if Treatment*, THE NEW YORK TIMES, July 21, 2003 (Op-Ed) at A15.

[85] Alan Feigenbaum, *Note: Special Juries: Deterring Spurious Medical Malpractice Litigation in State Courts*, 24 CARDOZO L.REV. 1361 (2003).

[86] Johnson et al., *supra* n.75.

[87] Courts in Alabama, Illinois, New Hampshire, North Dakota, Ohio, South Dakota, Texas and Washington have at various times found damage caps unconstitutional. See, e.g., American Medical Association, *supra* n.2, at 36-38; see also Gunnar, *supra* n.3, at 486. Courts in Florida, Illinois, Missouri, Pennsylvania, and Wyoming have at various times found screening panels unconstitutional. See Struve, *supra* n.14, at 56-57.

In states that have imposed caps, there is considerable variation as to the amount of the cap, and as to what sort of damages, exactly, are subject to the cap.[88] Similar problems await when one attempts to measure the success (or lack thereof) of screening panels. Some are mandatory, some are not. Some are physician dominated, some are not. Panel findings are admissible at trial in some states, inadmissible in others.[89]

The second reason why assessing what works and what doesn't work is the problem of compounding factors. If a state adopts more than one reform, and insurance rates stabilize, to which reform should the credit (if any) be given? If rates do not stabilize, to which reform should the blame be directed? Further, factors outside the control of the legislature have an influence on rates: the level of insurance losses sustained in the past year, the prime rate, and market performance are just a few possibilities.[90]

Caps on Damages

Caps come in many different styles and flavors.[91] Approximately half the states impose caps of some sort in medical malpractice cases.[92] Most of those states simply place a dollar limit on the amount of non-economic damages (i.e., pain and suffering, emotional distress, mental anguish) that may be recovered. Several states, however, limit the overall amount that may be

[88] See National Conference of State Legislatures, *State Medical Liability Laws Table*, at www.ncsl.org/programs/insur/medliability.pdf (site visited December 23, 2004).
[89] See Jean Macchiaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. WASH. L.REV. 181, 193(1990).
[90] Stephen Zuckerman et al., *Effect of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167, 168 (1990); Thorpe, *supra* n.2, at 21-24. See also United States General Accounting Office, *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, GAO-03-836 at 37 (2003).
[91] Limits on punitive damages can be thought of as a type of cap, as well. Many states restrict the amount of punitive damages that may be awarded, in one fashion or another. Punitive damages, however, are rarely an issue in medical malpractice cases. See Pace et al., *supra* n.31, at 59-60 (punitive damages awarded in less than 1% of the medical malpractice trials in California ending in a plaintiff's verdict).
[92] See Studdert 2004b, *supra* n. 72, at 54. See also American Medical Association, *supra* n.2, at 24.

recovered.[93] In some states, caps on damages are accompanied by limits on the plaintiff's attorney's fees.[94]

In their present incarnation, there are several significant problems with the use of caps. First, there is the fact that not all injuries are alike, and not all plaintiffs are alike. Caps have the effect of imposing a limit on the amount of damages a plaintiff may recover- regardless of how grievously he or she has been injured. This remains true even when attention is limited to non-economic caps. The fact that the "cap" if set high enough may only occasionally come into play merely lessens the problem: a limit has been imposed, and in at least some cases, that limit will mean that an injured party is less than fully compensated. There is, in other words, an inherent arbitrariness to caps.[95] The impact of caps does not seem to be limited to a small number of plaintiffs. A recent study of California medical malpractice verdicts found that the $250,000 cap on non-economic damages was imposed to reduce the plaintiff's recovery 51% of the time.[96] A similar study by the RAND Corporation Institute for Civil Justice reported that the $250,000 cap was imposed 45% of the time.[97]

As the severity of the claimant's injury increases, the chances increase that the cap will limit his or her recovery. On this point the available empirical evidence is consistent. Non-economic caps work to the special detriment of severely injured claimants who can show relatively little in

[93] States with caps on total damages (economic and non-economic) include Colorado, Indiana, Louisiana, Nebraska, New Mexico, and Virginia. See American Medical Association, *supra* n.2, at 25.
[94] California's statute, the Medical Injury Compensation Reform Act ("MICRA"), Cal. Civ. Code §3333.1-.2, enacted in 1975, is the most prominent example. Plaintiff's attorneys' fees in medical malpractice cases are limited to 40% of the first $50,000 recovered; 33 1/3% of the next $50,000 awarded; 25% of the next $500,000 awarded; and 15% of any amount awarded over $600,000. In 2004, Florida voters approved a constitutional amendment restricting attorneys' fees in medical malpractice cases as well. See FL. CONST. ART. I §26.
[95] See Studdert et al. 2004b, *supra* n.72, at 63; Maxwell Mehlman, *Resolving the Medical Malpractice Crisis: Fairness Considerations*, The Project on Medical Liability in Pennsylvania, 69-70 (2003),www. medliability.pa.org/research/mehlman0603/MehlmanReport.pdf, site visited October 31, 2004.
[96] Studdert et al. 2004b, *supra* n.72, at 57. Studdert's team collected jury verdict data for the period 1985-2002.
[97] Pace et al., supra n.31, at 21. The RAND study reviewed California verdicts from 1995-1999. Both the Studdert et al. study and the RAND study relied on data supplied by California Jury Verdicts Weekly. Because it is likely that smaller verdicts were under-reported, the actual percentage of "capped cases" may be somewhat less than 45%. See the discussion of this issue in Pace et al. at 63-64.

the way of economic losses. Typical examples would include cases involving deafness, disfigurement, or chronic pain.[98] Many wrongful death cases, and cases involving infants less than one year old also seem to be disproportionately affected by such caps.[99] Unless we are willing to say that no injury, no matter how grievous, is worth, say, more than $250,000 for pain and suffering, a cap has the effect of penalizing those who are most seriously injured by another's negligence.

Imposition of a cap also has the effect of exacerbating a disparity widely known in personal injury litigation: some lives are worth more than others. The same injury, sustained by two different people, can lead to very different recoveries. If non-economic damages are limited, then economic damages matter more. Thus, a 30 year old highly compensated stockbroker, now permanently disabled, will have economic damages (calculated on the basis of lost future earnings) far in excess of the economic damages sustained by a 30 year stay-at-home parent. In the absence of caps, non-economic damages can nonetheless be awarded to acknowledge that the pain and suffering of both the stockbroker and the stay at home parent are substantial. The stockbroker, due to his or her documented lost earnings, may still recover more than the stay at home parent; but the stay at home parent's recovery, already limited by the absence of significant economic damages, will not be limited a second time – unless caps are imposed. By exacerbating this sort of disparity, the use of caps has the secondary effect of further limiting access to the courts. Given the same sort of injury to two different people, one profitably employed and the other a stay at home parent, the odds are good that the latter will have a much more difficult time than the former finding a lawyer to represent her. In most parts of the country, a case capped at

[98] Studdert et al. 2004b, *supra* n.72, at 62.
[99] Pace et al., *supra* n.31, at 23-30.

$250,000 (if liability is established), with little in the way of economic damages, will not be a very attractive case for experienced attorneys to take.[100]

The second problem with caps is less theoretical. Legislation imposing caps has met with an uneven fate around the country. Efforts to implement caps on a national basis have, to date, been unsuccessful. At the state level, some courts have upheld the use of caps, and others have not.[101] In the states where caps have been found to be unconstitutional, there is of course an additional option. The cap can be made a part of the state constitution.[102] In the end, whether caps are constitutional or not seems besides the point. The amount of time it takes to resolve the question makes the value of the exercise doubtful, if what is needed is prompt change.

A third problem has to do with the law of unintended consequences. To what extent does the imposition of a cap on some types of injuries, and on some types of damages, distort personal injury litigation in general? If medical malpractice recoveries are capped, then an incentive arises to recast lawsuits originally styled as malpractice as something else- medical products liability claims, perhaps, or claims based on lack of informed consent- or to find new defendants to sue who are not protected under the terms of the cap legislation in question.[103]

Fourth, it is not at all clear that mandatory caps have worked. While there is solid evidence that caps do seem to reduce or at least restrain claim severity by limiting total jury

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[100] Studdert et al.2004b, *supra* n.72, at 63; Pace et al., *supra* n.31, at xxviii. It also appears that the imposition of non-economic caps has a greater impact on women, than on men. The RAND researchers found that the median reduction in total award for women, due to the MICRA cap, was 34%; in contrast, the median reduction for men was 25%. This may be because a higher percentage of the total award for women is attributable to non-economic damages. See Pace et al.at 32-33.

[101] Courts in 8 states have struck down mandatory caps, while courts in 15 states have upheld them. See Tanya Albert, *Challenge in State Courts: New Tort Reforms Under Fire*, amednews.com (November 1, 2004), available at www.ama-assn.org/amednews/2004/11/01/prl11101.htm; Albert Yoon, *Damage Caps and Civil Litigation: An Empirical Study of Medical Malpractice Litigation in the South*, 3 AMER. LAW & ECON. REV. 199, 201 (2001); National Conference of State Legislatures, *supra* n.82; Elizabeth Poisson, Comment, *Addressing the Impropriety of Statutory Caps on Pain and Suffering Awards in the Medical Malpractice System*, 82 N.C.L.REV. 759, 772 (2004).

[102] For example, in 2003 Texas voters approved Proposition 12, amending the Texas Constitution. See Vernon's Ann. Texas Const. Art. 3, §66 (2003) and Tex. Civ. Proc. & Rem. Code Ann. §74.301 et seq. (Vernon Supp. 2004) (imposing a cap on noneconomic damages of $250,000 per health care provider).

[103] See, e.g., Sage, *supra* n.2, at 16.

awards,[104] it is less clear that caps have a meaningful or lasting effect on malpractice insurance premiums. Thus, Zuckerman et al. in a 1990 study reported that "hard"caps (i.e., dollar limitations on all damages, both economic and non-economic) reduced premiums.[105] In a more recent study, Thorpe found that premiums in states with caps on damages were, on average, 17.1% lower than in states without caps on damages.[106] Nonetheless, the evidence is less than compelling.[107] Many factors affect malpractice insurance premiums. Some of those factors have little relation to tort reforms in general, or caps on non-economic damage awards in particular.[108] There is also the fact that the existence of caps does not necessarily insure against the appearance (or re-occurrence) of a crisis. In 2004 the AMA identified twenty states as "medical liability crisis states."[109] Eight of the crisis states (40%) had non-economic damage caps in place at the time,[110] although in six of those states, damage caps were less than two years old.[111] Of the thirty states not listed as being in crisis, nineteen (63%) had adopted cap legislation of some sort; eleven states (and the District of Columbia) had not.[112] The point seems to be that the imposition of caps lessens the chances of a "crisis," but does not guarantee against it.

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[104] Pace et al., *supra* n.31, at 20-23; Studdert et al. 2004a, *supra* n.2, at 288. See, generally, Studdert et al 2004b, *supra* n.72; Yoon, *supra* n.100.
[105] Zuckerman et al., *supra* n.90, at 175.
[106] Thorpe, *supra* n.2, at 26.
[107] For example, in June 2003 Weiss Ratings, Inc. issued a report challenging the view that damage caps had an appreciable effect on medical malpractice insurance premiums. See www.weissratings.com/malpractice.asp (site visited December 3, 2004). In an October, 2004 news release, the Foundation for Taxpayer and Consumer Rights made a similar claim, citing documents filed by GE Medical Protective, a large malpractice insurer, with the Texas Department of Insurance. See *Nation's Largest Medical Malpractice Insurer Declares Caps on Damages Don't Work, Raises Docs' Premiums*, www.consumerwatchdog.org/insurance/pr/pr004692.php3 (site visited December 3, 2004).
[108] See United States General Accounting Office, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*, GAO-03-702 (2003); Thorpe, *supra* n.2, at 27; Studdert et al. 2004a, *supra* n.2, at 288. It should also be noted that the 2004 RAND study of California's medical malpractice reforms did not attempt to measure the effect, if any, that damage caps have had on insurance premiums. See Pace et al., *supra* n.31, at 4.
[109] American Medical Association, *supra* n.2, at 8.
[110] Florida, Massachusetts, Mississippi, Missouri, Nevada, Ohio, Texas and West Virginia.
[111] In contrast, Massachusetts and Missouri both adopted caps in 1986.
[112] American Medical Association, *supra* n.2 at 8.

There is one last aspect to the use of caps that, though perhaps obvious, needs to be acknowledged. Caps are popular with doctors, insurers, and with many defense lawyers. Caps are not popular with plaintiffs, and with plaintiffs' lawyers. Any proposal to implement caps in a given state is certain to draw both strong support and strong opposition. In the event that caps are adopted by a given state, it is reasonable to expect constitutional challenges shortly thereafter- leaving the efficacy of the "reform" in doubt until the challenges are resolved, one way or the other. The point is simply this: when caps are proposed, there will be clear winners and clear losers, depending on the ultimate fate of the cap proposal.

Screening Panels

The story with respect to screening panels is also less than clear. The principle is certainly appealing. Medical malpractice liability turns on whether the relevant standard of care was met or not.[113] To determine this, the expert testimony of other physicians is almost always required.[114] Given this need for expert testimony, a pre-suit or pre-trial determination by a neutral panel, consisting of physicians and others, might have the effect of filtering out cases in which liability is unlikely to be shown. If all goes well for the defense, a public trial is avoided, and the defendant doctor is vindicated. Meanwhile, the plaintiff and his or her attorney have at least been spared the greater expense and delay of a full-blown trial- or they have at least been warned about the weakness of the case. If all does not go well for the defense, the plaintiff will know that pursuit of the claim is worthwhile. The defense will be on notice that a settlement may be worth pursuing.[115] As originally conceived, screening panels were intended to make the claims resolution process work more efficiently, by encouraging the settlement of meritorious

[113] DOBBS, *supra* n.59, at 631-34; WEILER 1991, *supra* n.8, at 19.
[114] DOBBS, *supra* n.59, at 639; DANZON 1985, *supra* n 16, at 16.
[115] Struve, *supra* n.14, at 55-56.

cases, and by identifying non-meritorious cases at an early stage.[116] The track record of screening panels has not borne out this sort of promise, however. At one time, more than thirty states used some sort of screening panel. Today, due to judicial challenges and legislative repeals, that number is down to twenty.[117] A principal shortcoming has been increased delay in the claims resolution process. [118]

The empirical studies have also been less than kind. Danzon found that screening panels had virtually no effect on medical malpractice litigation.[119] Zuckerman et al. likewise found that panels had no effect on the severity of paid claims, and had little effect on malpractice insurance premiums.[120] Goldman, examining the performance of peer assessments by physicians, found a surprisingly low level of consistency with respect to their medical conclusions. Because physician participation is an essential part of all screening panels, this finding casts doubt on the reliability of the conclusions reached by panelists regarding liability.[121] In sum, it is hard to escape the conclusion that screening panels offer little in the way of malpractice reform.

V. A Simple Proposal

Thirty years after the "first" malpractice insurance crisis, promising solutions remain elusive. It may be that the reforms of the past have been too ambitious. Perhaps we have tried to do too much, too quickly. We now find ourselves in a position where, it seems, any reform

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[116] Macchiaroli, *supra* n.89, at 186.
[117] Struve, *supra* n.14, at 57.
[118] Struve, *supra* n.14, at 62; Douglas Eitel et al., *Medicine on Trial: Physician Attitudes About Expert Medical Witnesses*, 18 J. LEGAL MED. 345, 351 (1997); Jona Goldschmidt, *Where Have All the Panels Gone? A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST.L.J. 1013, 1107 (1991).
[119] DANZON 1985, *supra* n.16, at 78, 198-202.
[120] Zuckerman et al., *supra* n.90, at 175-76.
[121] Ronald L. Goldman, *The Reliability of Peer Assessments of Quality of Care*, 267(7) JAMA 958, 959 (1992). See also K.L. Posner et al., *supra* n.52; Robert A. Caplan et al., *Effect of Outcome on Physician Judgments of Appropriateness of Care*, 265 JAMA 1957 (1991) (finding that the judgment of medical reviewers, regarding compliance with the standard of care, can be influenced by the reviewers' knowledge of the severity of the outcome).

significant enough to make a difference will necessarily produce clear winners and losers. The likely result is political impasse; the inevitable result is resentment all around. It is precisely this zero-sum aspect of the debate that makes a resolution difficult. With so much seemingly at stake, there is little reason not to simply adopt an entrenched position, and stay there. Any significant proposal will face an uncertain fate.

There is no reason for plaintiffs, and their attorneys, to favor the imposition of caps. There is, likewise, no reason for physicians, and their insurers, not to favor them. Maybe imposing caps will work, after all. Even if caps fail to have the desired effect, there will still be other benefits. Caps on damages have the effect of limiting the potential size of the fee a plaintiff's attorney can earn, from a given case. This is true whether the cap is applied to all damages, or only to non-economic damages. Thus, even if malpractice rates continue to rise, at least the plaintiff's malpractice bar will have been chastened. At a minimum, the economic incentive for bringing a malpractice lawsuit will have been curtailed. When limits are also imposed on the percentage of the recovery the plaintiff's lawyer is entitled to (typically referred to as "sliding scale" fees) the effect is even more pronounced.[122]

Why not change the incentives? Perhaps it is possible to give everyone a little something. It should be possible to give physicians and their insurers what they want- caps on non-economic damages- but in a way that makes the concession palatable to plaintiffs and their attorneys. At one level, this idea is nothing more elaborate than simple horse trading. It may be, though, that more is at stake.

[122] See, e.g., Pace et al., *supra* n.31, at 35-37(discussing the effect of California's rules). Imposing limits on the size of the fee a medical malpractice plaintiff's lawyer may charge, expressed in terms of a percentage of any award recovered, has become more popular of late. For example, in November 2004 Florida voters approved an amendment to the state constitution capping attorneys' fees in medical malpractice actions at 30% of any award recovered. See FL. CONST. ART. I §26.

Within bounds, the malpractice insurance system works well for many- but not all- of the key players. The insurer collects premiums from its insured physicians, invests the money, and uses the proceeds to defend (and occasionally indemnify) its insureds. In return, the insurer expects to make at least a modest profit. The insured physicians, in exchange for their premium payments, are assured that in the event of a lawsuit, a defense will be provided. If an indemnity has to be paid, the insurer will see to it. Defense lawyers are paid out of the premiums, or the income generated by the premiums. So too are plaintiffs' lawyers and plaintiff patients, when successful. It is an organic system in miniature, where the premium payments function as the life-blood. When only one of the key players is being shortchanged, the system can still function. When more than one key player is being shortchanged, "crisis" results. As the size of indemnity payments rises, so does the overall cost of defense.[123] The premiums needed to fund the system must also increase- but only to a point. Where that point lies depends on one's perspective, but it does exist. Beyond that point, more and more physicians stop buying insurance, or move to another jurisdiction, or stop practicing medicine. The result is less money generated from premiums to fund the system.

It is silly to think that increased costs of defense can be addressed simply by injecting more money into the system. Raising premiums and "passing the costs along" is no longer possible, if it ever was.[124] Instead, the distribution of the money that flows through the malpractice claims resolution system needs to be re-adjusted. By adjusting the distribution patterns, the overall level of money expended on the claims resolution system can be controlled. At the same time, the system as it now exists could be improved for all concerned. This could be done by setting up a system of separate "tracks" for medical malpractice cases. The plaintiff

[123] See SLOAN et al.1993, *supra* n. 24, at 172-73 (litigation cost varies systematically with size of the loss and defendant liability).
[124] See text accompanying n.7, *supra.*

alone would choose the track to use, determined by the amount of damages he or she plans to seek. The management of the case would differ, depending on the "track" chosen.

For example, three tracks could be made available: track one, for cases designated by plaintiff's counsel as involving $200,000 or less in damages; track two, for cases designated by plaintiff's counsel as involving $1,000,000 or less in damages; and track three, for all other cases- where there would be no limit imposed on damages. Choosing either track one or track two would thus set a limit on the maximum amount of damages potentially payable to the plaintiff. The key point would be that the limits would be agreed to, rather than imposed. The idea would be to provide plaintiff with strong incentives for choosing the appropriate track. To avoid needless costs associated with bargaining, participating insurers would commit themselves in advance to proceed under track one or track two, for any case, if the plaintiff so elects. In outline, such a system might look like this:[125]

Track One. In cases designated by plaintiff's counsel as involving $200,000 or less in damages, each side would be limited to designating just one expert to testify at trial. Depositions would not be permitted. Instead, each party would be required to submit a detailed statement of their expert's opinion. The expert's testimony at trial would be limited to the content of the statement submitted. Aggressive discovery scheduling orders would be used, as a way of reaching trial or other resolution in less than nine months. Use of mediation would be voluntary, available only if both parties requested it.[126] Track one, in other words, would be a no-frills alternative, in which costs are kept to a minimum.

[125] There is no magic to these particular dollar amounts. The amount of either or both thresholds could be altered, up or down. The reasons for proposing thresholds of $200,000 and $1,000,000 are discussed below.

[126] A number of states require mediation prior to trial. However, there is invariably a provision allowing the trial court to excuse mediation, for good cause shown, or something similar.

Track Two. In cases designated by plaintiff's counsel as involving $1,000,000 or less in damages, each side would be limited to designating no more than two experts per specialty. Deposition of those experts would be permitted. Aggressive discovery scheduling orders would also be a key feature of this track. The goal would be to reach trial or other resolution in twelve months or less. Mediation prior to trial would be required. The mediator would be drawn from a panel of mediators with experience in medical malpractice litigation.

Track Three. For all other cases, the plaintiff's counsel would not be required to indicate any limitation on the amount of damages to be sought. Pretrial discovery and case preparation would proceed as they do at present. However, the benefits of the other two tracks would not be available, either. There would be no limitation on the number or use of experts, and there would be no assurance of a prompt resolution of the case. Table 1 below compares the features of the three proposed tracks.

TABLE 1

Feature	Track One	Track Two	Track Three
Limits on the number of experts	One	Two per specialty	None
Deposition of experts allowed?	No- written statement only	Yes	Yes
Time to trial	Nine months or less	Twelve months or less	Whenever scheduled by the court
Mediation required?	No	Yes- mediator to have a background in medical malpractice	Yes, if required under existing law

Why Do It?

Not every medical malpractice case requires a full-blown entourage of experts proferred by the plaintiff and the defendant. Not every case is complex. Some cases that appear complex need not be. Yet the amounts expended on case prosecution and defense do not reflect this. Most malpractice cases are expensive to prosecute or defend, without regard to the particular issues involved, and without regard to the amount of money involved.[127] A key reason why almost all malpractice cases are so expensive has to do with the fixed costs of medical record review and the almost inevitable use of experts. In their study of civil trials in California, Gross and Syverud found that medical malpractice trials typically involve more expert testimony than all other types of tort litigation, with the exception of products liability cases. For trials conducted in 1990-91, the authors reported an average of 5.5 experts per medical malpractice trial.[128] This is often just the visible part of the iceberg. For every expert who testifies, it is likely that more than that number were consulted or retained. For at least every expert who testifies (and for some who never do) it is likely that they have been deposed, with the attendant expenses of deposition: travel expenses, expert preparation time, attorney time, and stenographic services.

The current claims resolution system provides little incentive to control costs. The threshold amounts of $200,000 for track one and $1,000,000 for track two are intended to sort cases by complexity- using the amount of money sought as a rough proxy for complexity. To a lesser extent, a three track system would also sort cases by the level of severity of the alleged injury.

The threshold amounts are meant to include all damages, economic and non-economic, as well as attorneys fees and costs. Plaintiffs ought to be able to decide which track to use, in light

[127] See Weiler 1993b, *supra* n.31, at 916; see also Vidmar and Brown, *supra* n.44 at 32.
[128] Gross and Syverud, *supra* n.36, at 33.

of their own assessment of damages. The sorts of classifications and distinctions required by a cap on just one sort of damage add needless complexity and argument. If the cap is expressed in terms of non-economic damages, there will always be some unfairness in their application.[129] It is simpler and wiser to leave the estimation of damages, of whatever sort, to the plaintiff and her attorney.

Restrictions on the number of experts, elimination or limitation of expert depositions, and a shortened time to trial are the common features of tracks one and two. By limiting the number of experts to be identified and deposed (or, as in track one, eliminating depositions altogether) the amount required for preparing for trial can be reduced dramatically. The minimum amount required both to pursue a medical malpractice action, and to defend a medical malpractice action will be reduced. It makes good sense to do so. The overhead associated with medical malpractice litigation- specifically, the amount paid lawyers, experts, economists and others- is famously high. The consensus view is that less than 50% of all the money spent by insurers on medical malpractice claims ends up in the pockets of injured patients. Most observers estimate that between 55% and 60% of all insurer expenditures go for expenses of one kind or another: plaintiff's attorneys' fees, defense attorneys' fees, expert fees, records review, and claims administration.[130] Much of that money would be better spent compensating more claimants, or reducing the insurers' costs of doing business, or some combination of both. Reducing the overhead required will also improve access to the courts. The high fixed costs involved in bringing a malpractice lawsuit have the effect of denying access to the courts for many claimants, whose claims, otherwise meritorious, are simply "not worth it" in the opinion of

[129] See text accompanying notes 95-100, *supra*.
[130] Studdert et al. 2004a, *supra* n.2 at 285-86; Danzon 2000, *supra* n.16, at 1369; Weiler 1993b, *supra* n. 31, at 916. A 2003 report by Tillinghast-TowersPerrin estimated a net return to plaintiffs in all personal injury torts (including medical malpractice) of 46%, out of all defense expenditures. Tillinghast-Towers Perrin, *supra* n.46, at 17.

counsel.[131] Improving access in turn will promote the two fundamental goals of tort law-compensation and deterrence.

Why $200,000?

Cases in which the plaintiff agrees to limit his or her overall recovery to $200,000 or less would be eligible for track one. The logic for using $200,000 as the ceiling for track one is simple. The fixed costs of case preparation on the plaintiff's side for any malpractice claim are likely to be at least $50,000.[132] Assuming a typical contingency agreement of 33 1/3%, in a $200,000 recovery, the plaintiff would receive between $80,000 and $100,000, depending on whether the fee is taken against the gross recovery of $200,000, or the net recovery of $150,000 after costs are recouped. To the extent that costs can be controlled or reduced, the recovery to the plaintiff would increase, under either scenario.[133]

The fact that a patient's actual injuries might be no more than $100,000 is not a reason to deny the patient compensation, from the party responsible for the injury. Only because we are accustomed to hearing about much larger medical malpractice verdicts do we think that a less-than-six figure injury is not substantial. If the context is changed- for example, from medical malpractice to a "slip and fall" in a local supermarket, a $100,000 injury seems more impressive.

Much of the overall expense of defending medical malpractice lawsuits can be attributed to relatively low-dollar cases. A high percentage of medical malpractice payments are less than $200,000. In 2003, for example, 15,291 payments on behalf of physicians were reported to the

[131] This is not a new phenomenon. See, e.g., Johnson et al., *supra* n.75, at 1367-68.
[132] See text accompanying notes 38-39, *supra*.
[133] If the attorney's fee is taken from the gross proceeds, the net recovery to the plaintiff would be computed as follows: $200,000- (1/3 of $200,000) - $50,000 costs = $83,400. If the attorney's fee is taken from the net proceeds, the recovery to the plaintiff would be computed as follows: $200,000 - $50,000 costs – (1/3 of $150,000) = $100,000. If costs turn out to be $40,000, rather than $50,000, the net recovery to the plaintiff increases, to either $93,400 or $106,720, respectively.

National Practitioner Data Bank.[134] 8983 of those payments (58.7%) were in an amount less than $200,000.[135] The sum of payments of less than $200,000 was approximately $718,928,600, representing 16.1% of all payments reported to the Data Bank on behalf of physicians in 2003. However, the important number is not the percentage total of all payments reported to the Data Bank. Instead, the frequency of these relatively small payments is more significant. For virtually every one of these payments,[136] a substantial amount of money was likely spent prosecuting and defending the claim. For any lawsuit alleging medical malpractice, regardless of the amount the plaintiff seeks, there will be substantial expenses that neither side will be able to avoid, such as the cost of obtaining and reviewing medical records, the cost of locating and recruiting potential experts, and the cost of deposing the experts designated by the other side. On average, defense costs will be in excess of $25,000 per case, and in excess of $50,000 for the plaintiff.[137] Numbers this large should not be ignored. Because of the inevitable fixed costs of record review, expert recruitment and depositions, low dollar cases are not necessarily cheaper to defend (or pursue) than high dollar cases. Furthermore, given the ways of pre-trial discovery, and the absence of limits on the number of experts in particular, a party often has the ability to impose additional costs on the opposing party. For example, more experts can be designated than will be needed, requiring additional discovery depositions.

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[134] The National Practitioner Data Bank was established by Congress in Title IV, section 421 of Public Law 99-660, and codified as the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11131. The Act requires that any amount paid by an insurer on behalf of a physician must be reported to the Data Bank. Whether liability was ever established is not relevant. There is some reason to suspect that not all such payments are, in fact, reported. See Joseph T. Hallinan, *Doctor is Out: Attempt to Track Malpractice Cases is Often Thwarted,* Wall Street Journal, August 27, 2004, A1.

[135] National Practitioner Data Bank Public Use Data File, November 2004, U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Practitioner Data Banks.

[136] Most, but not all payments reported to the Data Bank were the result of lawsuits.

[137] In 1998,the average cost of defending a medical malpractice case (regardless of outcome) was $24,669, according to the PIAA. Even non-payment cases were expensive; the average cost of defending no-payment cases was $20,045. PIAA, *supra* n.31 at 2. See also note 76, *supra.*

Certainly many, if not most of the low dollar payments reported to the Data Bank originated as claims that contemplated significantly higher amounts. Still, the fact remains that in the end, the plaintiff and her attorney were willing to accept these relatively modest amounts- for better or worse. The point is, that to arrive at even these modest amounts in settlement, a large amount of money had to be spent on the costs of defending and prosecuting these cases. The money could be better spent elsewhere.[138]

A Cap on All Damages?

The distinction between economic and non-economic damages is difficult to rationalize. Some injuries, even though severe, do not usually lead to significant economic damages.[139] Some injuries, even though not severe, may often lead to significant economic damages. Unfair results, particularly when analyzed in terms of vertical equity, seem inevitable.[140] It would be simpler, and wiser, to allow plaintiffs to decide how they wish to proceed, in light of their own assessment of damages. If the damages do not seem enormous, and the need for a prompt resolution is present, then either track one or track two will offer an attractive alternative. Otherwise, the plaintiff should be free to seek whatever amount she believes she is entitled to. Injecting the distinction between economic and non-economic damages into the process is simply not worth the effort.

[138] The percentage of low dollar payments does appear to be decreasing over time, however. In 1999, payments of less than $200,000 accounted for 69.2% of all payments reported to the Data Bank. This pattern is consistent with the view that claims severity has been increasing over the past several years.
[139] See generally Studdert et al.2004b, *supra* n.72. Studdert et al. point out, for example, that injuries such as deafness or disfigurement, although severe, are not usually accompanied by significant economic loss. See also Poisson,*supra* n.100, at 783; Mehlman, *supra* n.95, at 69; Paul Weiler, *Fixing The Tail: The Place of Malpractice in Health Care Reform,* 47 RUTGERS L.REV. 1157, 1180 (1995).
[140] Id.

What Kinds of Cases?

Payment data from the NPDB offers a glimpse of the types of cases that are likely to fit the parameters of track one and track two. Beginning in early 2004, the NPDB began to provide data on severity of the injury alleged, using a nine-level scale ranging from "1," emotional injury only, to "9," death. Table 2 sets out the number, average and median payments made, by severity category. Table 2 also sets out the percentage of cases, within each severity category, in which less than $200,000 and $1,000,000, respectively, was paid.

Table 2

Payment by Severity Category

n= 9194

Severity of Injury	Number of Cases	Average Payment	Median Payment	Pct. Of Cases < $200,000	Pct. Of Cases < $1,000,000
Emotional injury only	123	$73,502	$37,500	94.3%	0.0%
Insignificant injury	162	$65,830	$17,500	92.6%	0.0%
Minor temporary	910	$78.321	$37,500	90.8%	0.2%
Major temporary	850	$178,107	$115,000	72.5%	0.4%
Minor permanent	1086	$180,666	$97,500	73.0%	0.8%
Significant permanent	1441	$339,617	$225,000	46.8%	2.9%
Major permanent	949	$478,251	$325,000	32.3%	5.6%
Quadriplegic, brain damage, lifetime care	471	$800,968	$495,000	5.9%	12.3%
Death	3021	$282,639	$195,000	54.8%	1.4%

Source: National Practitioner Data Bank, Public Use Data File, November 2004.

Emotional injuries, insignificant injuries, and minor temporary injuries seem well-suited for track one. Over 90% of the reported awards for these three categories were for less than $200,000. Track one might also prove attractive for many major temporary injury and minor permanent injury cases. Over 72% of the reported awards for those two categories were for less than $200,000.

Track two should be attractive to all categories of injury severity, with the exception of category 8 (quadriplegic, brain damage, lifetime care), and possibly category 7, major permanent injury. Only for level 8 does the percentage of million-dollar cases exceed 10%. Most death cases (category 9) should be suitable for either track one or track two. Death cases represent almost one-third (3021/9194) of the payments reported for 2004. The average indemnity payment for death cases was $282,639. Less than 1.5% of such payments exceeded $1,000,000.

The choice of what track to use will remain with the plaintiff, of course. Nonetheless, the data are suggestive. For most injuries, much time and expense could be saved by opting for track one or track two, with little risk of forgoing a larger award

More Lawsuits?

Reducing the overhead associated with medical malpractice litigation cuts both ways, of course. If it will cost less to defend a case, it will cost less to prosecute a case. A three track system might therefore increase the number of lawsuits filed, at least initially. The increase would be most likely for track one cases- i.e., cases in which the plaintiff seeks no more than $200,000 in damages. This might well prove to be a benefit to all concerned.

It is important to understand a potential $200,000 recovery in context. Under current practice, even assuming that the full $200,000 is recovered, the plaintiff's net recovery would likely be not much more than $100,000. Assuming a minimum of $50,000 in pre-trial expenses that will have to be paid, and assuming a standard contingency fee of 33 1/3 %, at most $83,400 will be left for the plaintiff.[141] If the attorneys' fees are calculated on the basis of net recovery (gross recovery, less expenses), the plaintiff's recovery will be a bit higher- but still no more than half of the gross amount recovered. If only $100,000 is obtained, the net recovery to the plaintiff may well be less than $20,000.[142] Furthermore, these examples assume likely liability on the part of the physician. If there is a significant chance of no recovery, the dollar value of the recovery (if obtained) would need to be higher, to offset the increased risk of recovering nothing. It should not be surprising, therefore, that cases valued at $200,000 or less are precisely the cases that rarely get filed. Given the high rate of under-claiming by victims of medical negligence[143] perhaps a higher volume of low stakes litigation is exactly what's needed.

More lawsuits may be the way to re-direct medical malpractice litigation to one of the fundamental goals of tort law: compensation. More lawsuits *might* mean more payments to more injured people. If such proved to be the case, it would not necessarily mean greater payments overall to claimants, due to the effect of the caps agreed to for track one and track two. The result instead would be greater horizontal equity among claimants with similar injuries. More important, the *possibility* of more lawsuits would mean greater access to the courts for injured patients. At present, for malpractice injuries that cannot be valued in excess of $200,000, access to the courts is virtually nonexistent. In order to secure the services of an experienced plaintiff's attorney, the minimum amount is actually much higher. It is important to understand that this

[141] See the computations described at n. 133, *infra*.
[142] Assuming again $50,000 of expenses and a fee of around $33,000.
[143] See text accompanying n.16-17, *supra.*

problem of very limited access exists even in the absence of caps legislation. When legislatively imposed caps are introduced, access to the courts becomes even more constrained.[144]

For claims valued at more than $200,000 but less than $1,000,000, the availability of track two might also increase the number of lawsuits filed. Reducing the number of experts, and assuring a resolution of the case within twelve months would lower the costs and the risks of bringing a lawsuit. As a result, more economically marginal cases might be filed. Examples would include cases in which liability is uncertain or doubtful, but damages, if proved, would exceed $200,000; or cases in which damages probably exceed $200,000, but realistically are worth no more than several hundred thousand dollars. Cases such as these would become more attractive to plaintiffs' lawyers.

In addition to promoting the tort law goal of compensation, an increase in the number of lawsuits would promote the goal of deterrence as well, by improving the signaling process. When a mistake has been made, followed by an injury, the party allegedly responsible should know about it. The party responsible should also know the outcome of the claim. These things happen- eventually- under existing practice. But they do not happen in predictable fashion, and they do not happen quickly.Instead, most injuries, even injuries caused by error, do not lead to a claim, much less a lawsuit.[145] When a claim is made, or a lawsuit is filed, resolution of the matter is certainly months away, and likely more than two years away.[146] When the resolution occurs, it will most likely take the form of either a voluntary dismissal (meaning the plaintiff simply abandoned the case) or a monetary settlement. Either way, there has been no determination of fault made by a court. Rarely is either vindication or condemnation the result for the defendant physician. The goal of deterrence goes unserved if the message (either vindication or

[144] See Pace et al., *supra* n.31, at 26.
[145] See discussion at notes 16-17, *supra.*
[146] See Johnson et al., *supra* n.75 at 1371.

condemnation) is so seldom sent. Increasing the volume of cases would change this pattern. There would be more resolutions of all types, including judgments. Because of the streamlined process required for tracks one and two, the outcomes would be known sooner.

So where is the benefit to defendants? That benefit appears when another result of the tracking system is considered: the costs of defending a claim will be reduced, just as the plaintiff's costs of preparing a claim will be reduced. There will be less reason to settle to avoid the high costs of trial. In fact, reducing the costs of defense should have the effect of reducing, overall, the amount offered by the insurer to settle the case. Reductions in settlement amounts would then follow.[147]

If the case proceeds under either track one or track two, the maximum amount recoverable will be within the limits of many, if not most medical liability policies written today.[148] With the threat of potential personal liability removed, there will be less incentive to settle for reasons unrelated to actual fault. In other words, a defendant who genuinely feels she has not been negligent will find it easier to resist the temptation to settle, and instead insist on her day in court. She will not be risking personal liability for any excess judgment.[149]

More Trials?

Far more malpractice cases settle than ever go to trial.[150] Thus, the effect that a three track system would have on trial and settlement rates needs to be considered. There is a

[147]Twenty years ago, Danzon ran a number of simulations to determine the effect on medical malpractice litigation that a hypothetical 30% reduction in litigation costs for both sides would have. Danzon concluded that such a reduction would result in a reduction in average settlement amounts, an increase in the trial rate, and a decrease in the number of cases dropped without payment by the plaintiff. DANZON 1985, *supra* n.16, at 48-49.
[148] The most common liability limits written for medical malpractice are $1,000,000 per event, and $3,000,000 per year. GAO, *Multiple Factors*, *supra n.*3 at 6.
[149] Most professional liability policies contain a clause requiring the insured's consent to settle a claim. See Peeples et al. 2002, *supra* n.26, at 880; Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1172-1177 (1990).
[150] See text accompanying note 29, *supra*.

possibility that more trials would result. The reason for this is that for track one and track two cases, insurers will know that their potential exposure is now limited. Freed of the risk of excessive awards, insurers might be inclined to offer less than before for the same sort of injury. After all, the defense wins much more often than it loses at trial, and everyone knows that.[151] Even in the face of the historically long odds that going to trial represents, plaintiffs may still conclude that they are better off going to trial. After all, the trial preparation will be less expensive than before, and the time to trial has been reduced. Put another way, when the transaction costs are reduced, pursuing a case to verdict makes more sense. Plaintiffs will discount their claims less, and defendants will make corresponding adjustments to the amount they are willing to pay in settlement. [152] Still, going to trial will make sense only if a careful analysis of the merits of the case has been done prior to filing the lawsuit.

Just as with an increase in filings, an increase in the trial rate would yield benefits to all. There is reason to believe that plaintiffs pay a substantial discount from the value of their claims when they agree to settlement.[153] The payments reported to the Data Bank support this view. In 2003, for example, the median award at trial (as reported to the NPDB) was $255,000. In contrast, the median settlement amount was $155,000. Even allowing for the savings to be expected in not going to trial, the disparity is still striking.[154] A similar result can be found at the high end of the scale. In 2003, 9.2% of all jury awards were in excess of $1,000,000. Only 2.7% of all settlements exceeded $1,000,000. For defendants, the prospect of more trials- conducted quickly and at less expense- might be the most efficient way, over time, to discourage frivolous

[151] See text accompanying note 31, *supra*.
[152] DANZON 1985, *supra* n.16, at 48.
[153] SLOAN et al.1993, *supra* n.24 at 206-7; see also Stephen Spurr and Walter Simmons, *Medical Malpractice in Michigan: An Economic Analysis*, 21 J.HEALTH POL. POL'Y & L. 315, 340-41 (1996).
[154] It is certainly possible that cases with greater amounts at stake go to trial more often. One way to test this would be to control for severity of injury in comparing awards at trial to settlement amounts. In other words, a completely disabling injury might, or might not, net about the same amount, whether at trial, or in settlement. However, NPDB data on severity of injury is only available for 2004 forward.

lawsuits. The battle will be over the merits of the claim. The recurring temptation to settle rather than incur defense costs that would exceed the likely settlement will be lessened.

Fewer Large Awards

One of the most frequently cited problems with medical malpractice litigation is the steady increase in claim severity.[155] The trend is especially evident in the past several years. The size of payments of all types- judgments and settlements- has increased noticeably.[156] The use of the three track system should have the effect of reducing the number of awards in excess of $1,000,000.The restrictions on the use of experts and the promise of a prompt resolution should be enough to lure some cases that might otherwise result in a "runaway" jury award into the confines of track two. For example, imagine a case with a likely settlement value of $500,000. Under present practice, there is always the possibility that the plaintiff will come away with an award far in excess of $500,000- perhaps $1,000,000, perhaps much more. Both sets of lawyers will be aware of the possibility of a "jackpot" award. The potential for a very large award becomes an argument in favor of settlement, that plaintiff's counsel is likely to invoke- sometimes successfully, sometimes not. When plaintiff's counsel decides to take advantage of the benefits of lower pretrial overhead, and shorter time to resolution, the possibility of a very large award disappears. In other words, a three track system should have the effect of screening out cases that, objectively viewed, are not worth seven figures, but, in the hands of a skilful advocate and a sympathetic jury, just might be. At present, there is no reason not to go for the jackpot award, at least in the lawsuit's early stages. With a three track system in place, there will be good reasons to refrain from going for the jackpot award. Since jury verdicts provide the key

[155] See Studdert et al. 2004a, *supra* n.2 at 286; Thorpe, *supra* n.2 at 21, 23.
[156] In 1999, the median payment (judgments and settlements) was $105,000. In 2003, the median payment (judgments and settlements) was $155,000.

reference point for settlements,[157] restraining the amount of jury verdicts will have a moderating effect on settlement amounts as well.

Longer Term Effects

Use of a three track system would have two beneficial effects, with respect to the behavior of plaintiff's counsel. First, the availability of different tracks will encourage counsel to value their cases realistically, from the start of the representation. It will make little sense to "default" to track three for a case truly worth no more than $200,000; the result will be needless delay and expense. Realistic case evaluation, early in the representation, should have the effect of correcting inflated expectations that the client may have- expectations that may make a settlement harder to obtain later in the development of the case, when the weaknesses of the case become apparent. Second, the availability of different tracks means that counsel will need to discuss the filing options with the client. That will mean explaining the benefits and the disadvantages of a less expensive, speedier resolution. It should also mean that plaintiffs will assume a greater say in the prosecution of their claims. They will need to decide whether a prompt resolution, with limited expense but bounded by a voluntary cap on damages is more desirable than an opportunity, however slight, to recover a larger sum, with the attendant higher expenses and greater time to resolution. At present, plaintiffs do not have to make this determination, even though in many cases an award of less than $1,000,000, or even less than $200,000, would adequately compensate them for their injury.

[157] Daniels and Martin, *supra* n.38 at 1804-07; Sloan and Hsieh 1990, *supra* n. 24 at 1026.

Large Dollar Cases: Track Three

Of course, there will be cases where the amount of potential damages is truly in excess of $1,000,000. There will also be very complex cases which, in the opinion of plaintiff's counsel, require the use of multiple experts. Nonetheless, there should not be many such cases.

First of all, a review of reports to the NPDB since 1990 shows that payments of any type in excess of $1,000,000 are quite uncommon; judgments in excess of $1,000,000 are more uncommon still. In 2003, 97.1% (14,851 out of 15,296) of all payments were for $1,000,000 or less.[158] Such payments accounted for 79.6% of all the payments reported to the Data Bank for 2003. Of those payments, 426 represented jury verdicts; only 43 judgments in excess of $1,000,000 were reported to the Data Bank in 2003. Even allowing for the recent increase in severity of indemnity payments, these numbers indicate that very large payments still remain very much the rare exception to a more moderate pattern. In any event, the fact that the median and mean awards are increasing in amount is all the more reason to provide incentives not to seek such large amounts, except when plainly warranted. Voluntary caps can provide such an incentive.

Second, it needs to be understood that true multi-million claims will often, of necessity, involve defendants other than a physician or two. Hospitals will likely be co-defendants. The reason for this is pragmatic. The most common liability limits for a medical malpractice policy are $1,000,000 per event, and $3,000,000 per year.[159] Deeper pockets will be needed, in other words. Yet once hospitals become critical (if not primary) defendants, the policy issues change. No longer is the concern, necessarily, driving individual physicians out of practice. It is easy enough to rally political support for Dr. Marcus Welby; it is a more difficult task to rally political

[158] As with payments of $200,000 or less, this percentage has declined over the past several years. In 1999, 98.5% of all payments were for $1,000,000 or less.
[159] See n. 146, *supra.*

support for a faceless medical center. Even more important, it is at the institutional level that deterrence might actually work- not with individual physicians.[160] We should aim the cannon in that direction, then.

Effects on Settlement

It is widely understood that in order to settle a lawsuit for, say, $500,000 the plaintiff must begin by demanding a much higher number, perhaps even higher than $1,000,000. This is a key feature of the process of positional negotiation that most lawyers use.[161] If the maximum award is now capped at $1,000,000, how does the settlement dance change? Realistically, an experienced plaintiff's lawyer would agree to a $1,000,000 cap only if the true "goal" is considerably less than $1,000,000- and so the defense will assume. Room must be left for the plaintiff to make concessions. For similar reasons, an insurer wishing to initiate settlement talks will begin with an offer considerably less than the amount it is willing to pay- and so the plaintiff's lawyer will assume.

Does this mean that in practice, a $1,000,000 voluntary cap will attract only claims valued by the plaintiff's lawyer as worth, say, no more than $500,000? That would be an unfortunate result, because it would mean that fewer cases are being "captured" by this second track. In effect, it would mean a de facto cap of no more than $500,000 - $600,000, where perhaps a net of $350,000, at most, goes to the injured patient.[162] It doesn't have to be this way.

A three-track system would change the traditional choreography of the settlement dance. The effect of choosing track one or track two will be to reduce the time to trial to twelve months

[160] Mello and Brennan 2002, *supra* n.8, at 1623.
[161] See, e.g., HOWARD RAIFFA, THE ART AND SCIENCE OF NEGOTIATION 47-49 (1982); CHARLES B. CRAVER, EFFECTIVE LEGAL NEGOTIATION AND SETTLEMENT 4th Ed. 151-55 (2001).
[162] I.e., $600,000 gross recovery, less $200,000 contingency fee, and less $50,000 in expenses.

or less. The parties will have to make a choice: either bargain realistically, or go to trial. In a system where trial is never more than twelve months away, the opportunity (and incentive) for posturing and intransigence will be lessened. Knowing that a bluff can be called in short order, there should be less temptation to do so in the first place. Use of a three track system would place the emphasis in case resolution where it ought to be: on the merits.[163]

A larger question regarding settlement must also be considered, however. Most medical malpractice lawsuits are disposed of in one of two ways. Either they are abandoned unilaterally, or they are settled. The settlement rate for medical malpractice cases is much higher than the trial rate. Various studies have estimated the settlement rate, for filed cases, at around 50%.[164] In contrast, the trial rate is estimated at between 5.8%[165] and 11%.[166] Would fewer cases settle, under a three-track system?

Perhaps so. Twenty years ago, Danzon concluded that a 30% reduction in litigation costs for both sides would result in more trials, and fewer cases dropped without payment.[167] The effect would be temporary, however. Over time, lawyers will learn what suits not to bring. A three track system rewards plaintiffs' lawyers who are adept at picking cases that have real value, by reducing both the overhead and the carrying costs associated with malpractice litigation. The system punishes insurers who refuse to settle cases that should be settled. Under tracks one and two, the incentive for delay is diminished, since a prompt trial is assured. The opportunity to settle on terms more favorable than trial will still exist, but with a trial in the near future, the

[163] The alternative would be to build in the room needed to stage the settlement dance. For example, the limits of track one and track two could be doubled, to $400,000 and $2,000,000, respectively. The assumption would be that these two tracks are aimed at cases realistically valued at $200,000 and $1,000,000.
[164] See text accompanying n. 29, *supra*.
[165] See American Medical Association, *supra* n.2 at 3 (using data supplied by Physician Insurers Association of America).
[166] See Weiler 1995, *supra* n.139 at 1163. In any event, there is general agreement that the trial rate for medical malpractice cases is higher than for other tort claims. See note 28, *supra.*
[167] DANZON 1985, *supra* n.16, at 48-49.

opportunity will be shorter. In the end, the result will be a more efficient and more rational system.

One other benefit to a three track system should not go overlooked. This proposal can be implemented without enabling legislation. All it takes is a willingness to experiment on the part of one or more insurers, at least some plaintiffs' attorneys, and the local trial courts. The details could be expressed in nothing more elaborate than a discovery scheduling order. Samples of such orders appear in the appendix.

Conclusion

A three track system will not, of itself, cure the medical malpractice insurance crisis. A true cure will require changes much larger than what is proposed here. Nonetheless, it is a start. Precisely because the changes that will be required will be substantial, it is unrealistic to think that they can be adopted with one bold step. When it comes to malpractice reform, we need to learn how to crawl before we can learn how to walk.

APPENDIX

PROPOSED EXPEDITED DISCOVERY SCHEDULING ORDER

(Track One Cases)

THIS MATTER having come on for hearing before the undersigned presiding Judge, on the date indicated below, and the Court hereby finding that this is an action alleging medical malpractice; that the parties wish to bring this action to a prompt resolution, and in any event within nine months of the date indicated below;

and that the parties have agreed that in no event shall the amount of money awarded or paid to the plaintiff exceed $200,000;

the Court therefore finds that it would be in the best interest of justice for an Expedited Scheduling and Pre-trial Order to be entered.

THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the parties to this action shall comply with the following Order:

[ASSUME, for illustration purposes, that the date of the order is January 1]

1. The parties shall each be limited to designating a single expert witness.

2. On or before March 1, the Plaintiff shall identify the expert witness s/he intends to call at the trial of this action.

3. On or before April 1, the Defendant shall identify the expert witness s/he intends to call at the trial of this action.

4. As used in this Order, the term “identify” when used in the context of expert witnesses shall mean the furnishing of the following information about each such expert:

(a) name and address

(b) training and qualifications (or curriculum vitae)

(c) a detailed statement setting forth the subject matter upon which the expert is expected to testify; a detailed statement of the facts and opinions to which the expert is expected to testify; and the basis for each opinion, including medical records, deposition testimony, and any other materials the expert has reviewed.

5. All discovery of any nature and description whatsoever shall be concluded on or before August 1. This case shall be set for trial to begin on or before October 1.

6. Any expert witness not identified in conformity with this Order shall not be permitted to testify at the trial of this action. The testimony of all expert witnesses shall be limited to the information specified in paragraph 4(c) of this Order.

7. The parties agree that in no event shall an amount in excess of $200,000, including both economic and non-economic damages as well as attorneys fees and pre-judgment interest, be paid to the Plaintiff, whether in settlement or as a result of a jury verdict. In the event of an award in excess of $200,000, the plaintiff agrees to accept a reduction in the amount of the award to $200,000. The parties further agree that in no event will punitive damages be sought or awarded.

8. Plaintiff agrees to authorize the release of any and all medical records of the plaintiff within one week of the date of this Order.

9. The parties agree that the right of the parties to appeal an adverse judgment or other dispositive ruling shall be unaffected by this order.

10. This Order may be modified by written agreement of all parties.

So ordered, this the 1st day of January, 20__.

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Judge

CONSENTED TO:

[attorney for plaintiff]

[attorney for defendant]

PROPOSED EXPEDITED DISCOVERY SCHEDULING ORDER

(Track Two Cases)

THIS MATTER having come on for hearing before the undersigned presiding Judge, on the date indicated below, and the Court hereby finding that this is an action alleging medical malpractice; that the parties wish to bring this action to a prompt resolution, and in any event within twelve months of the date indicated below;

And that the parties have agreed that in no event shall the amount of money awarded or paid to the plaintiff exceed $1,000,000;

the Court therefore finds that it would be in the best interest of justice for an Expedited Scheduling and Pre-Trial Order to be entered.

THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the parties to this action shall comply with the following order:

[Assume, for illustration purposes, that the date of the order is January 1]

1. The parties shall each be limited to designating no more than two expert witnesses.

2. On or before March 1, the plaintiff shall identify the expert witnesses s/he intends to call at the trial of this action. By March 15, the plaintiff shall make such expert witnesses available for any discovery depositions the defendant may wish to conduct.

3. On or before May 1, the defendant shall identify the expert witnesses s/he intends to call at the trial of this action. By June 15, the defendant shall make such expert witnesses available for any discovery depositions the plaintiff may wish to conduct.

4. As used in this Order, the term “identify” when used in the context of expert witnesses shall mean the furnishing of the following information about each such expert:

(a) name and address;

(b) training and qualifications (or curriculum vitae);

(c) a statement setting forth the subject matter upon which the expert is expected to testify, a summary of the facts and opinions to which the expert is expected to testify; and the basis for each opinion, including medical records, deposition testimony, and any other materials the expert has reviewed.

5. All discovery of any nature and description whatsoever shall be concluded on or before October 1. This case shall be set for trial to begin on or before December 1.

6. Any expert witness not identified in conformity with this Order shall not be permitted to testify at the trial of this action.

7. The parties agree that in no event shall an amount in excess of $1,000,000, including both economic and non-economic damages as well as attorneys fees and pre-judgment interest, be paid to the plaintiff, whether in settlement or as a result of a verdict. In the event of an award in excess of $1,000,000, the plaintiff agrees to accept a reduction in the amount of the award to $1,000,000. The parties further agree that in no event will punitive damages be sought or awarded.

8. Plaintiff agrees to authorize the release of any and all medical records of the plaintiff within one week of the date of this Order.

9. The parties agree that the right of the parties to appeal an adverse judgment or other dispositive ruling shall be unaffected by this Order.

10. This Order may be modified by written agreement of all parties.

So ordered, this the 1st day of January, 20__.

_____

Judge

CONSENTED TO:

[attorney for the plaintiff]

[attorney for the defendant]

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